New Jersey Department of Health and Senior Services
Assisted Living Program

APPLICATION FOR APPROVAL OF A CERTIFIED MEDICATION AIDE TRAINING AND COMPETENCY EVALUATION PROGRAM (MATCEP) IN ASSISTED LIVING RESIDENCES/ASSISTED LIVING PROGRAMS/ COMPREHENSIVE PERSONAL CARE HOMES

STATE USE ONLY
☐ Approved
☐ Not Approved

Mailing Address
Assisted Living Program
PO Box 367
Trenton, NJ 08625-0367

Overnight Services (DHL, FedEx, UPS)
Assisted Living Program
120 South Stockton Street, Lower Level
Trenton, NJ 08611-1730

*Instructions: PLEASE PRINT LEGIBLY OR TYPE. One copy of the **Medication Aide Course Agenda** and the **Addendum of Course Attendees** must accompany this application form, along with a check for $100, payable to the "NJ Department of Health and Senior Services (DHSS)."*

*To allow for appropriate staff review and processing, the application **MUST** be received by the Assisted Living Program at least three (3) weeks prior to the requested start date.*

***NOTE:** The Clinical Med Pass Site **MUST** be licensed by the Department of Health and Senior Services.*

FROM: (Name and Address of Facility/School)	Name of Contact Person	Telephone Number ( )
	Email Address	County

Date Course Begins	Date Course Ends	Dates of Clinical Med Pass	Number of Students	Name and Address of Main Clinical Med Pass Site

Name and Address of Classroom Site	*If additional Med Pass Sites are utilized, check this box ☐ and attach a separate page with facility name, address, contact person, telephone number and email address.*

Name of Nurse Instructor	Last 4 Digits of Social Security Number	Check Type of Instructor		Registered Nurse - NJ License		
		Class-room	Clinical	Nursing License Number	Current Date of Issue	Date of Expiration
		☐	☐			
		☐	☐			
		☐	☐			

Name of Supplemental Staff (Delegating RN and RPh)	Last 4 Digits of Social Security Number	Check Type of Credential		NJ License		
		RN	Reg. Pharm.	License Number	Current Date of Issue	Date of Expiration
		☐	☐			
		☐	☐			
		☐	☐			

Name (Print) of Residence/Program/Home Administrator/Director	Telephone Number
Signature of Residence/Program/Home Administrator/Director	Date

FOR STATE USE ONLY

Facility Code	School Code	Approved? ☐Yes ☐No	Approval Period - Two (2) Years From: To:	Check or MO No.

This application has been reviewed and approved by the Assisted Living Program. Any changes to this application form and/or this schedule MUST first be submitted to the Assisted Living Program (FAX - 609-633-9060) with a request for approval of the change(s). You MAY NOT implement any change(s) without the approval of the Assisted Living Program. Thank you for your cooperation.

Signature of Representative, Assisted Living Program	Date

Retain a copy for your records.
NA-4 Forward the original to the Assisted Living Program at one of the addresses shown above.
JUL 08 After approval, a copy will be mailed to the contact person and to the Assisted Living Administrator.